BRUCE A. CHERNOF, M.D.
Acting Director and Chief Medical Officer

JOHN R. COCHRAN, III
Chief Deputy Director

WILLIAM LOOS, M.D.
Acting Senior Medical Officer

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
313 N. Figueroa, Los Angeles, CA 90012
(213) 240-8101

January 26, 2006

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, California 90012

Dear Supervisors:

PHYSICIAN SERVICES FOR INDIGENTS PROGRAM (PSIP): APPROVAL OF ADDITIONAL FUNDING, FISCAL YEAR 2005-06 TRAUMA AND EMERGENCY PHYSICIAN SERVICES AGREEMENTS, OFFICIAL COUNTY FEE SCHEDULE AND REIMBURSEMENT RATES, AND APPROPRIATION ADJUSTMENT
(All Districts) (4 Votes)

IT IS RECOMMENDED THAT YOUR BOARD:

1. Approve and authorize the Acting Director of Health Services, or his designee, to offer revised trauma and emergency physician services agreements for Fiscal Year (FY) 2005-06, substantially similar to Exhibit I, including the Official County Fee Schedule (OCFS) and revised reimbursement rates effective July 1, 2005, substantially similar to Exhibit II, to eligible non-County physicians providing services at non-County trauma and emergency hospitals.

2. Delegate authority to the Acting Director of Health Services, or his designee, to make administrative language revisions to the PSIP policies and procedures, as required by State law, upon prior review and approval by County Counsel and Chief Administrative Office.

3. Approve an additional allocation of up to a total of $4.8 million in "Measure B" Trauma Property Assessment (TPA) funding to enable full payment of all claims by non-County physicians for trauma services provided at non-County trauma hospitals for FYs 2004-05 and 2005-06.

4. Approve an appropriation adjustment to allocate $4.8 million in "Measure B" TPA funds from Appropriation for Contingencies to Services and Supplies in the Department's FY 2005-06 Final Budget.

PURPOSE/JUSTIFICATION OF THE RECOMMENDED ACTIONS:

Official County Fee Schedule (OCFS) And Revised Reimbursement Rates

Approval of Recommendation No. 1 will reduce the initial reimbursement rate for non-County physician emergency services claims, effective July 1, 2005, to 29% of the OCFS, and authorize the Acting Director of Health Services to offer new trauma and emergency physician services agreements (that include minor technical changes) which incorporate the OCFS and the revised emergency services reimbursement rate for FY 2005-06.

The initial non-trauma emergency services reimbursement rate must be reduced to help ensure there are sufficient funds to provide an equivalent reimbursement rate for all projected claims for FY 2005-06 emergency services. Continuing with the current reimbursement rate (34% of OCFS) for non-trauma emergency services could result in less than full-year funding. Should a significant amount of funding remain after payment of all claims at the recommended initial payment rate (29% of OCFS), a supplemental payment may be made, not to exceed 34% of OCFS, as specified in Exhibit II.

PSIP Policies and Procedures Revision

Approval of Recommendation No. 2 will allow the Department to make appropriate revisions to the County's PSIP policies and procedures, as required by State law governing the funding sources for the PSIP.

Trauma Physician Funding

Approval of Recommendation No. 3 will authorize spending additional TPA funding of approximately $4.8 million for FYs 2004-05 ($2.5 million) and 2005-06 ($2.3 million). For FY 2004-05, approximately $0.7 million in TPA funding was previously approved to pay non-County physician trauma services claims; thus, allocation of an additional $2.5 million is required to provide total TPA funding of $3.2 million for payment of FY 2004-05 physician trauma services claims at the current reimbursement rate (50% of OCFS), which is necessary for the continued viability of the trauma and emergency care system in Los Angeles County.

The Department's FY 2005-06 Final Budget includes $1.1 million in TPA funding for payment of PSIP claims for physician trauma services at non-County trauma hospitals. Therefore, allocation of an additional $2.3 million is required to provide total TPA funding of approximately $3.4 million for payment of FY 2005-06 physician trauma services claims at the current reimbursement rate (50% of OCFS), which is necessary for the continued viability of the trauma and emergency care system in Los Angeles County.

The Department will only utilize the additional allocation of TPA funding to the extent needed after all other available revenue sources have been expended.

Appropriation Adjustment

Approval of Recommendation No. 4 will transfer $4.8 million in FY 2005-06 TPA funding from Appropriation for Contingencies to Services and Supplies. This is required to enable utilization of these monies, to the extent necessary, to pay FY 2004-05 and FY 2005-06 non-County physician trauma services claims.

FISCAL IMPACT/FINANCING:

Physician Trauma Services

There are projected to be total additional expenditures of approximately $4.8 million in TPA funds to pay all FY 2004-05 ($2.5 million) and FY 2005-06 ($2.3 million) PSIP claims for trauma services. There are sufficient funds in the TPA Appropriation for Contingencies ($18.7 million as reflected in the FY 2005-06 Final Budget) to enable this transfer and expenditure of $4.8 million.

For subsequent fiscal year budgets, the Department will work with the Chief Administrative Office to include up to a maximum of $3.5 million in TPA funding, only to the extent necessary after considering all other projected revenue sources in subsequent fiscal year budgets, to help ensure that all claims for the provision of physician trauma services are paid at the current reimbursement rate (50% of OCFS).

Physician Emergency Services

Funding for PSIP physician emergency services claims, to the extent available, will be provided entirely (100%) by Emergency Medical Services Appropriation (EMSA), SB 612 (Maddy), and Proposition 99 Tobacco Tax (CHIP) funds, except for St. Francis Medical Center physician emergency services claims for which $1.2 million in TPA funding was previously approved.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS:

In 1987, the California Legislature enacted Chapter 1240, Statutes of 1987, allowing counties to establish an Emergency Medical Services Maddy fund to compensate physicians and medical facilities for non-trauma emergency services provided to indigent patients. The funds (SB 612 funds) are derived from additional penalties assessed on fines and bail forfeitures that the courts collect for certain criminal offenses and motor vehicle violations. Early in the program, the annual deposits to the County's PSIP exceeded reimbursements, creating a surplus maintained in a growing reserve fund. This reserve fund totaled $12.0 million at the end of FY 2000-01. Factors that have reduced this reserve fund to $0.2 million at the end of FY 2004-05 are: increased physician participation in the reimbursement program, an increase in reimbursement rates prompted by problems maintaining physician call panels for hospital emergency departments, legislation placing a limit on the amount of reserve funds allowed, a decrease in annual SB 612 revenues, and a decrease in Proposition 99 revenues.

In October 1989, the Governor signed into law AB 75 (Chapter 1331; Statutes of 1989) which contained provisions for the distribution of Proposition 99 Tobacco Tax revenues. AB 75 established the California Healthcare for Indigents Program (CHIP), a program which appropriates Statewide funding for hospitals, physicians and other health services for indigent persons. These funds are allocated to counties based primarily on each county's share of the financial burden of providing health services to those who are

unable to pay. AB 75 dictates the portion of these funds that must be allocated to the County's PSIP. Over the years, Proposition 99 funding for the PSIP steadily decreased, with no funding provided in FY 2002-03 or FY 2003-04. The decline in this revenue source greatly contributed to the increasing use of the SB 612 reserve fund to maintain the OCFS. There has been some restoration of Proposition 99 funding in FY 2004-05 (approximately $310,000) and FY 2005-06 (approximately $4.1 million), however there is no guarantee that this funding source will continue in the future.

Starting in FY 2001-02, to partially restore diminishing Proposition 99 funds available for the PSIP, the State's budget has included an EMSA effective FY 2001-02, specifically for reimbursement of non-trauma emergency physician services provided to indigent patients.

On February 22, 2005, the Board approved the Trauma Center Service Augmentation Agreement with St. Francis Medical Center which established provisions and funding for increased emergency room and trauma patient volume, and an appropriation adjustment to allocate $3.0 million in "Measure B" Appropriation for Contingencies funds, of which $1.4 million was appropriated to backfill a shortfall of other State and local funding needed to maintain the current physician reimbursement rates for the PSIP at St. Francis Medical Center and the Countywide non-County Physician Trauma Services for Indigents Program.

In the event the State legislature should revise existing law governing administration of PSIP funding sources, it may be necessary to accordingly revise the County's PSIP policies and procedures.

In the early 1990s, DHS established the Physician Reimbursement Advisory Committee (PRAC) pursuant to provisions of the State of California Welfare and Institutions Code ("WIC"), sections 16950, et seq., and Health and Safety Code ("HSC"), section 1797.98a, et seq., as an advisory committee to DHS to make recommendations on physician reimbursement policies and procedures and to review appeals of adjudicated or denied claims. The membership is comprised primarily of physicians representing such organizations as the Los Angeles County Medical Association, the California Chapter of the American College of Emergency Physicians, and the County's Trauma Hospital Advisory Committee. Other members represent the Hospital Council of Southern California, billing agencies, and DHS. The PRAC supports the recommendations.

County Counsel has reviewed and approved Exhibits I and II as to use and form.

Attachment A provides additional information.

CONTRACTING PROCESS:

Any non-County physician providing trauma or emergency services to indigent patients at non-County hospitals, including non-County trauma centers, is eligible to participate in the PSIP by completing the FY 2005-06 Conditions of Participation Agreement and the Enrollment Form.

IMPACT ON CURRENT SERVICES (OR PROJECTS):

Approval of "Measure B" TPA for trauma patients only will help ensure the ability of hospitals to fill their Emergency Department physician call panels, and may potentially mitigate the evolving emergency

services crisis in the County. Approval of the OCFS County Fee Schedule and revised reimbursement rates will enable payment of all submitted claims for FY 2005-06.

When approved, this Department requires three signed copies of the Board's action.

Respectfully submitted,

Bruce A. Chernof, M.D.
Acting Director and Chief Medical Officer

BAC:af
BLETCD4190.CBA

Attachments (1)

c: Chief Administrative Officer
County Counsel
Executive Officer, Board of Supervisors
Auditor-Controller

ATTACHMENT A

SUMMARY OF REVISION REQUEST

1. TYPE OF REVISION:

FY 2005-06 Official County Fee Schedule and reimbursement rates for eligible non-County physicians providing services at non-County trauma and emergency hospitals under the Physician Services for Indigents Program, and the agreements which incorporate the reduced reimbursement rates.

2. AGENCY ADDRESS AND CONTACT PERSON:

Department of Health Services
Emergency Medical Services (EMS) Agency
5555 Ferguson Drive, Suite #220
Commerce, California 90022
Attention: Carol Meyer, Director
Telephone: (323) 890-7545

3. TERM:

Effective retroactively to July 1, 2005 through June 30, 2006.

4. FINANCIAL INFORMATION:

There will be total maximum additional expenditures of approximately $4.8 million, in TPA funds, to the extent necessary, to pay all FY 2004-05 and FY 2005-06 PSIP claims for trauma services. There are sufficient funds in the TPA Appropriation for Contingencies to enable this transfer and expenditure. Funding for PSIP emergency services claims, to the extent available, will be provided entirely by Emergency Medical Services Appropriation (EMSA), SB 612 (Maddy), and Proposition 99 Tobacco Tax (CHIP) funds; except for St. Francis Medical Center emergency services claims for which $1.2 million in TPA funding was previously approved.

5. GEOGRAPHIC AREA SERVED:

Countywide.

6. ACCOUNTABLE FOR PROGRAM MONITORING:

EMS Agency

7. APPROVALS

Health Services Administration:	Bruce A. Chernof, M.D., Acting Director and Chief Medical Officer
EMS Agency:	Carol S. Meyer, Director
Contracts and Grants Division	Cara O'Neill, Chief
County Counsel (approval as to use and form):	Edward A. Morrissey, Deputy

76R 352M 11/83

BOARD OF SUPERVISORS
OFFICIAL COPY

COUNTY OF LOS ANGELES

REQUEST FOR APPROPRIATION ADJUSTMENT DEPT'S. No. _____

DEPARTMENT OF Health Services DATE 01/26/2006

AUDITOR CONTROLLER.
THE FOLLOWING APPRPRIATION ADJUSTMENT IS DEEMED NECESSARY BY THIS DEPARTMENT. WILL YOU PLEASE REPORT AS TO ACCOUNTING AND AVAILABLE BALANCES AND FORWARD TO THE CHIEF ADMINISTRATIVE OFFICER FOR HIS RECOMMENDATION OR ACTION.

ADJUSTMENT REQUESTED AND REASONS THEREFOR

Budget Adjustment
Fiscal Year 2005-06
(4-VOTE)

Please see attached for details.

JUSTIFICATION:

The appropriation adjustment in the amount of $4,806,000 is necessary to reallocate Measure B Trauma Property Assessment funds from Appropriation for Contingencies to Services and Supplies to pay all Fiscal Year 2004-05 ($2,540,000) and Fiscal Year 2005-06 ($2,266,000) Physician Services for Indigents Program (PSIP) Trauma Services claims.

EM:bsr
01/26/06

1/26/06
Efrain Muñoz, Chief
DHS-Controller's Division
6:30pm

CHIEF ADMINISTRATIVE OFFICER'S REPORT

REFERRED TO THE CHIEF ADMINISTRATIVE OFFICER FOR:
☐ ACTION
☒ RECOMMENDATION

APPROVED AS REQUESTED ☑ AS REVISED ☐

JANUARY 30, 2006
DAVID E. JANSSEN
CHIEF ADMINISTRATIVE OFFICER

AUDITOR-CONTROLLER No. 256

BY: _____
JAN 30 2006

APPROVED (AS REVISED):
BOARD OF SUPERVISORS

BY: _____
DEPUTY COUNTY CLERK

SEND 6 COPIES TO THE AUDITOR-CONTROLLER

DEPARTMENT OF HEALTH SERVICES
BUDGET ADJUSTMENT
FISCAL YEAR 2005-06

(4 VOTES)

SOURCES:		USES:	
Measure B Account (BW9)		**Measure B Account (BW9)**	
Appropriation for Contingencies - 3303	$ 4,806,000	Services & Supplies - 2000	$ 4,806,000
Total DHS	**$ 4,806,000**	**Total DHS**	**$ 4,806,000**

NOTED AND APPROVED

Efrain Munoz, Chief
DHS-Controller's Division

BA #256 4-VOTE B.A.
JAN 30, 2006

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

TRAUMA PHYSICIAN SERVICES PROGRAM

FISCAL YEAR 2005/06
CONDITIONS OF PARTICIPATION AGREEMENT

SUBMIT TO: AMERICAN INSURANCE ADMINISTRATORS (AIA)
BOX 34759
LOS ANGELES, CALIFORNIA 90034-0759

The undersigned physician (hereinafter "Physician") certifies that claims submitted hereunder are for trauma services provided by him/her at a County contract trauma hospital to trauma patients who does not have health insurance coverage for emergency services and care, and who cannot afford to pay for services rendered, and for whom payment will not be made through any private coverage or by any program funded in whole or in part by the federal government.

Physician acknowledges receipt of a copy of the "Trauma Physician Services Program Billing Procedures" (hereinafter "Billing Procedures"), promulgated by the County of Los Angeles, Department of Health Services, for fiscal year 2005/06, the terms and conditions of which are incorporated herein by reference.

Physician agrees that all obligations and conditions stated in the Billing Procedures will be observed by him/her, including, but not limited to, the proper refunding of monies to the County when patient or third-party payments are made after reimbursement under this claiming process has been received; the cessation of current, and waiver of future, collection efforts upon receipt of payment; and the preparation, maintenance, and retention of service and finance records, including their availability for audit. Physician affirms that for all claims submitted, reasonable efforts to identify third-party payers have been made, no third-party payers have been discovered, and no payment has been received.

Physician agrees to assign and subrogate all rights that s/he may have against any patient, his/her responsible relative, any third party tortfeasor or any other party for reimbursement as a result of care and services provided by Physician, and/or his/her staff, for which a claim has been submitted to County under the Trauma Physician Services Program. At its sole discretion, County, and/or its contractor, may proceed independently against such parties for reimbursement to the extent permitted by law. The rights hereby assigned and subrogated to County under this provision include reimbursement for the full amount of any customary or actually billed charges of Physician, and his/her staff, for patient care and services regardless of the amount the Physician has received under the or Trauma Physician Services Program. Physician agrees to cooperate with County and/or its contractors in the exercise of the rights assigned and subrogated to County under this provision.

Physician expressly acknowledges and accepts that any County liability for claims submitted hereunder is at all times subject to conditions defined in the Billing Procedures, including, but not limited to, (1) availability of monies, (2) priority of claim receipt, and (3) audit and adjustments. In accordance with instructions in the Billing Procedures, Physician agrees to submit required documents for claims, and provide other patient data as may be required by the County.

Physician certifies that information on claims submitted by him/her is true, accurate, and complete to the best of his/her knowledge.

_____
TYPED/PRINTED NAME OF PHYSICIAN

_____ _____
PRIMARY SPECIALTY OF PHYSICIAN SIGNATURE OF PHYSICIAN

_____ _____
STATE LICENSE NUMBER DATE

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

TRAUMA PHYSICIAN SERVICES PROGRAM

BILLING PROCEDURES

• • • Revised for Fiscal Year 2005/06 • • •

I. INTRODUCTION

Pursuant to provisions of the State of California Welfare and Institutions Code, sections 16950 et seq., and Health and Safety Code ("HSC"), sections 1797.98a, et seq., a Physician Services Account has been established by the County of Los Angeles ("County") to pay for contracts with private physicians ("Physician") to provide reimbursement for certain professional services they have rendered to eligible indigent patients. County has determined that a portion of the Physician Services Account should be allocated to a special County sub-account which will serve as a source of reimbursement for otherwise uncompensated physician services rendered to trauma patients in hospitals designated by County contract as trauma hospitals.

This document defines the procedures which must be followed by a Physician in seeking reimbursement from this trauma services sub-account. Reimbursement is also limited to the policy parameters set forth in the "Department of Health Services' Physician Reimbursement Policies, Revised for Fiscal Year 2005/06", attached as Exhibit "A" and incorporated herein by reference. The County may revise such policies from time to time as deemed necessary or appropriate and if approved by the Board of Supervisors.

Submission of a claim for trauma services by a Physician under these procedures establishes (1) a contractual relationship between the County and the Physician covering the services provided and (2) signifies the Physician's acceptance of all terms and conditions herein.

This claiming process is only valid for trauma services rendered during the period July 1, 2005 through June 30, 2006.

In no event may this claiming process be used by a Physician if his/her services are included as part of the trauma hospital services claimed for reimbursement by the hospital under County's contract with the hospital.

This claiming process may not be used by a Physician for services for which a billing has previously been submitted or could be submitted to the County under any other County contract or claiming process.

This claiming process may not be used by a physician if he or she is an employee of a County trauma hospital.

II. PHYSICIAN ELIGIBILITY

A. The Physician must complete a current fiscal year Trauma Physician Services Program "Conditions of Participation Agreement" and "Program Enrollment Provider Form" and provide them to the County's Office of Emergency Medical Services ("EMS") Agency in care of the contracted Claims Adjudicator (see address on page 4). Physician claims will not be accepted if said Agreement and form are not on file with the EMS Agency. A copy of the "Conditions of Participation Agreement" and "Program Enrollment Provider Form" are attached hereto as Exhibit "B" and incorporated herein by reference.

B. Any Physician, **including an emergency department Physician**, who responds as part of an organized system of trauma care to eligible patients in a hospital designated by formal County contract as a "trauma hospital" may submit a claim hereunder. (Physician employees of a County trauma hospital are not, however, eligible for reimbursement under this claiming process.)

III. PATIENT ELIGIBILITY/BILLING EFFORTS

Only patients for whom the trauma hospital is required to complete a trauma patient summary ("TPS") form, and who does not have health insurance coverage for emergency services and care, and who cannot afford to pay for services rendered, and for whom payment will not be made through any private coverage or by any program funded in whole or in part by the federal government, including Medi-Cal, are covered by this claiming process.

During the time prior to submission of the bill to the County, the Physician must have made reasonable efforts to obtain reimbursement and not received payment for any portion of the amount billed. For purposes of this claim process, reimbursement for unpaid Physician billings shall be limited to the following:

(a) patients for whom a Physician has conducted reasonable inquiry to determine if there is a responsible private or public third-party source of payment; and

(b) patients for whom a Physician has billed all possible payment sources, but has not received reimbursement for any portion of the amount billed; and

(c) either of the following has occurred:

1. A period of not less than three (3) months has passed from the date the Physician billed the patient or responsible third party, during which time the Physician has made reasonable efforts to obtain reimbursement and has not received payment for any portion of the amount billed.

2. The Physician has received actual notification from the patient or responsible third party that no payment will be made for the services rendered.

Upon receipt of payment from the County on a claim hereunder, the Physician must cease any current, and waive any future, collection efforts to obtain reimbursement from the patient or responsible third party. During the period after a claim has been

submitted and prior to receipt of payment, the Physician can continue attempts to collect from a patient. However, once the Physician receives payment from the County, further collection efforts shall cease.

If, after receiving payment from the County hereunder, the Physician is reimbursed by a patient or a responsible third party, the Physician shall immediately notify the County (see address below) in writing of the payment, and reimburse the County the amount received from the County.

MAKE REFUND CHECK PAYABLE TO:

County of Los Angeles
Department of Health Services

Refund checks should be accompanied by:

-- a copy of the Remittance Advice, and
-- a detailed explanation for the refund, e.g., received a payment for services from Medi-Cal, etc.

SUBMIT NOTIFICATION AND/OR REFUND TO:

County of Los Angeles
Department of Health Services
Fiscal Services
313 North Figueroa Street, Room 505
Los Angeles, CA 90012
ATTN: CHIP Program

IV. CONDITIONS OF REIMBURSEMENT

Payment is contingent upon adherence to State law and County requirements regarding eligible claims, and provision of data as specified in these Billing Procedures.

V. CLAIM PERIOD

Claims may only be submitted for eligible services provided on/or after July 1, 2005 and before July 1, 2006. All claims for services provided during the fiscal year 2005/06 (July 1 through June 30) must be received no later than October 31, 2006. Claims received after the fiscal year deadline has passed will not be paid. Unless sooner terminated, canceled, or amended, this claim process shall expire on October 31, 2006.

VI. REIMBURSEMENT

Reimbursement of a valid claim hereunder will be limited to a maximum of 50% of the Official County Fee Schedule (OCFS), not to exceed 100% of Physician charges. The OCFS, which establishes rates of reimbursement deemed appropriate by the County, utilizes the most current Physicians' Current Procedural Terminology (CPT-4) codes in conjunction with the Resource Based Relative Value Scale (RBRVS) unit values and a County determined weighted average conversion factor. The conversion factor for all

medical procedures other than anesthesiology is $79.49 per relative unit value. The conversion factor for anesthesiology procedures is $48.77 per relative unit value.

VII. COMPLETION OF FORMS

A. Complete "Fiscal Year 2005/06 Conditions of Participation Agreement" for the current fiscal year Trauma Physician Services Program (sample attached). Submit one original signed Agreement to the contracted Claims Adjudicator:

American Insurance Administrators ("AIA")
Box 34759
Los Angeles, CA 90034-0759

B. Complete one HCFA-1500 Form per patient.

C. Complete one California Healthcare for Indigents Program ("CHIP") Form per patient (sample attached as Exhibit "D"). Physicians are required to provide patient data for services provided in a hospital to the extent the information is available from the hospital. Additional requirements for data submission have been established. Refer to the Instructions for Submission of Claims and Data Collection (attached as Exhibit "C").

VIII. ELECTRONIC BILLING

As an option, the contracted Claims Adjudicator can receive claims electronically. The record layout necessary for electronic submission shall be obtained directly from the contracted Claims Adjudicator at (310) 390-7900.

IX. SUBMIT CLAIM(S) TO COUNTY'S CONTRACTED CLAIMS ADJUDICATOR

American Insurance Administrators (AIA)
P.O. Box 34759
Los Angeles, California 90034-0759
Attention: TRAUMA CLAIMS

X. CLAIM REJECTION AND APPEALS

A. Revised claims previously rejected for incomplete information must be received by the contracted Claims Adjudicator within twenty (20) calendar days of the rejection letter.

B. The Physician must submit an appeal of any denied claim within thirty (30) calendar days from the date of the denied Remittance Advice. A denied claim can be appealed once; however, after the appeal is dispositioned, a further appeal will not be considered. All appeals shall be prepared and sent in accordance with the directions set forth in Exhibit "A".

XI. INFORMATION CONTACTS

For Status of Claims, call:
AIA Physician Hotline - 1 (800) 303-5242

For Program/Policy Issues, call:
Emergency Medical Services Agency
EMS Reimbursement Coordinator
(323) 890-7521

XII. COUNTY LIABILITY/PAYMENT/SUBROGATION

Payment of any claim under this claiming process is expressly contingent upon the availability of monies specifically allocated by the State and by the County of Los Angeles Board of Supervisors. To the extent such monies are available for expenditure, valid claims presented to the County may be paid. Valid claims will be paid in order of their receipt by the County; that is, if a complete and correct claim is received by County, it will have priority over claims subsequently received.

Physician agrees to assign and subrogate all rights that s/he may have against any patient, his/her responsible relative, any third party tortfeasor or any other party for reimbursement as a result of care and services provided by Physician, and/or his/her staff, for which a claim has been submitted to County under the Trauma Services for Indigents Program. At its sole discretion, County, and/or its contractor, may proceed independently against such parties for reimbursement to the extent permitted by law. The rights hereby assigned and subrogated to County under this provision include reimbursement for the full amount of any customary or actually billed charges of Physician, and his/her staff, for patient care and services regardless of the amount the Physician has received under the Trauma Services for Indigents Program. Physician agrees to cooperate with County and/or its contractors in the exercise of the rights assigned and subrogated to County under this provision.

XIII. GENERAL OBLIGATION OF PHYSICIANS SUBMITTING CLAIMS

In addition to any Physician duties specified previously herein, Physicians using this claiming process are obligated as follows:

A. Records/Audit Adjustment

1. The Physician shall immediately prepare, and thereafter maintain, complete and accurate records sufficient to fully and accurately reflect the services provided, the costs thereof, all collection attempts from the patient and third-party payers, and collection revenue, if any, for which claim has been made under this claiming process.

2. All such records shall be retained by the Physician at a location in Los Angeles County for a minimum of three (3) years following the last date of the Physician services to the patient.

3. Such records shall be made available during normal County working hours to representatives of the County and/or State, upon request, at all reasonable times during such three year period for the purpose of inspection, audit, and copying. Photocopying capability must be made available to County representatives during an on-site audit.

4. County may periodically conduct an audit of the Physician's records. Audits shall be performed in accordance with generally accepted auditing standards. The audit may be conducted on a single claim, a group of claims, or a statistically random sample of claims from the adjudicated universe for a fiscal year. The scope of the audit shall include an examination of patient medical and financial records, patient/insurance billing records, and collections agency reports associated with the sampled claims.

Audited claims that do not comply with program requirements shall result in a refund to the County. If the audit was conducted on a statistically random sample of claims, the dollar amount disallowed shall become a percentage of the total paid on the sample, referred to as the exception rate. The audit exception rate found in the sampled claims reflects, from a statistical standpoint, the overall exception rate potentially possible within the universe of adjudicated claims for that fiscal year. This exception rate shall be applied to the total universe of paid claims which will determine the final reimbursement due to the County.

If an audit of the Physician records conducted by County and/or State or representatives relating to the services for which claim was made and paid hereunder finds that (1) the records are incomplete or do not support the medical necessity for all or a portion of the services provided, or (2) no records exist to evidence the provision of all or a portion of the claimed services, or (3) the Physician failed either to report or remit payments received from patients or third parties as required herein, or (4) the patient was ineligible for services hereunder, or (5) the Physician did not otherwise qualify for reimbursement hereunder, the Physician shall, upon receipt of County billing therefor, remit forthwith to the County the difference between the claim amount paid by the County and the amount of the adjusted billing as determined by the audit.

County also reserves the right to exclude the Physician from reimbursement of future claims for any failure to satisfy conditions of this claiming process.

B. Indemnification/Insurance

By utilizing this claiming process, the Physician certifies that the services rendered by him/her, and for which claim is made, are covered under a program of professional liability insurance with a combined single limit of not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) aggregate.

By utilizing this claiming process, the Physician further certifies that his/her workers' compensation coverage is in an amount and form to meet all applicable requirements of the California Labor Code, and that it specifically covers all persons providing services on behalf of the Physician and all risks to such persons.

C. Non-Discrimination

In utilizing this claiming process, the Physician signifies that he/she has not discriminated in the provision of services for which claim is made because of race, color, religion, national origin, ancestry, sex, age, physical or mental disability, or medical condition and has complied in this respect with all applicable non-discrimination requirements of Federal and State law.

XIV. COMPLIANCE WITH HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

The parties acknowledge the existence of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ('HIPAA'). Contractor understands and agrees that, as a provider of medical treatment services, it is a 'covered entity' under HIPAA and, as such, has obligations with respect to the confidentiality, privacy, and security of patients' medical information, and must take certain steps to preserve the confidentiality of this information, both internally and externally, including the training of its staff and the establishment of proper procedures for the release of such information, and the use of appropriate consents and authorizations specified under HIPAA.

The parties acknowledge their separate and independent obligations with respect to HIPAA, and that such obligations relate to transactions and code sets, privacy, and security. Contractor understands and agrees that it is separately and independently responsible for compliance with HIPAA in all these areas and that County has not undertaken any responsibility for compliance on Contractor's behalf. Contractor has not relied, and will not in any way rely, on County for legal advice or other representations with respect to Contractor's obligations under HIPAA, but will independently seek its own counsel and take the necessary measures to comply with the law and its implementing regulations.

CONTRACTOR AND COUNTY UNDERSTAND AND AGREE THAT EACH IS INDEPENDENTLY RESPONSIBLE FOR HIPAA COMPLIANCE AND AGREE TO TAKE ALL NECESSARY AND REASONABLE ACTIONS TO COMPLY WITH THE REQUIREMENTS OF THE HIPAA LAW AND IMPLEMENTING REGULATIONS RELATED TO TRANSACTIONS AND CODE SET, PRIVACY, AND SECURITY. EACH PARTY FURTHER AGREES TO INDEMNIFY AND HOLD HARMLESS THE OTHER PARTY (INCLUDING THEIR OFFICERS, EMPLOYEES, AND AGENTS), FOR ITS FAILURE TO COMPLY WITH HIPAA.

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

PHYSICIAN SERVICES FOR INDIGENTS PROGRAM

FISCAL YEAR 2005/06
CONDITIONS OF PARTICIPATION AGREEMENT

SUBMIT TO: AMERICAN INSURANCE ADMINISTRATORS (AIA)
BOX 34759
LOS ANGELES, CA 90034-0759

The undersigned physician (hereinafter "Physician") certifies that claims submitted hereunder are for emergency, obstetric, or pediatric services provided by him/her to patients who does not have health insurance coverage for emergency services and care, and who cannot afford to pay for services rendered, and for whom payment will not be made through any private coverage or by any program funded in whole or in part by the federal government.

Physician acknowledges receipt of a copy of the "Physician Services for Indigents Program (PSIP) Billing Procedures" (hereinafter "Billing Procedures"), promulgated by the County of Los Angeles, Department of Health Services, for fiscal year 2005/06.

Physician certifies that claims for emergency services shall only be submitted for emergency services provided on the calendar day on which emergency services are first provided and on the immediately following two calendar days (except for eligible trauma patients provided services at County contract trauma hospitals through a separate program, the Trauma Physician Services Program).

Physician agrees that all obligations and conditions stated in the Billing Procedures will be observed by him/her, including, but not limited to, the proper refunding of monies to the County when patient or third-party payments are made after reimbursement under this claiming process has been received; the cessation of current, and waiver of future, collection efforts upon receipt of payment; and the preparation, maintenance, and retention of service and finance records, including their availability for audit. Physician affirms that for all claims submitted, reasonable efforts to identify third-party payers have been made, no third-party payers have been discovered, and no payment has been received.

Physician agrees to assign and subrogate all rights that s/he may have against any patient, his/her responsible relative, any third party tortfeasor or any other party for reimbursement as a result of care and services provided by Physician, and/or his/her staff, for which a claim has been submitted to County under the PSIP. At its sole discretion, County, and/or its contractor, may proceed independently against such parties for reimbursement to the extent permitted by law. The rights hereby assigned and subrogated to County under this provision include reimbursement for the full amount of any customary or actually billed charges of Physician, and his/her staff, for patient care and services regardless of the amount the Physician has received under the PSIP. Physician agrees to cooperate with County and/or its contractors in the exercise of the rights assigned and subrogated to County under this provision.

Physician expressly acknowledges and accepts that any County liability for claims submitted hereunder is at all times subject to conditions defined in the Billing Requirements, including, but not limited to, (1) availability of monies in the PSIP, (2) priority of claim receipt, and (3) audit and adjustments. In accordance with instructions in the Billing Procedures, Physician agrees to submit required documents for claims, and provide other patient data as may be required by the County.

Physician certifies that information on claims submitted by him/her is true, accurate, and complete to the best of his/her knowledge.

_____
TYPED/PRINTED NAME OF PHYSICIAN

_____ _____
PRIMARY SPECIALTY OF PHYSICIAN SIGNATURE OF PHYSICIAN

_____ _____
STATE LICENSE NUMBER DATE

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

PHYSICIAN SERVICES FOR INDIGENTS PROGRAM

BILLING PROCEDURES

• • • Revised for Fiscal Year 2005/06 • • •

I. INTRODUCTION

Pursuant to provisions of the State of California Welfare and Institutions code ("WIC"), sections 16950, et seq., and Health and Safety Code ("HSC"), sections 1797.98a, et seq., a Physician Services for Indigents Program ("PSIP") has been established by the County of Los Angeles ("County") to provide reimbursement to private physicians ("Physician") for certain professional services that have been rendered in Los Angeles County to eligible indigent patients. Professional physician services herein referred to are limited to emergency services as defined in WIC, section 16953; obstetric services as defined in WIC, section 16905.5; and pediatric services as defined in WIC, section 16907.5.

Professional physician services which can be reimbursed under this claiming process are additionally restricted as prescribed by the County, with such restrictions subject to revision from time to time. Current County physician reimbursement restrictions are set forth in "Department of Health Services Physician Reimbursement Policies, Revised for Fiscal Year 2005/06", attached as Exhibit "A" hereto and incorporated herein by reference. The County has discretion to revise such policies from time to tome as deemed necessary or appropriate and if approved by the Board of Supervisors.

In no event may this claiming process be used by Physician if his/her services are included in whole or in part in hospital or physician services claimed by a hospital or by Physician under a separate formal contract with County. Nor may this claiming process be used if Physician has previously billed County for his/her emergency, obstetric, or pediatric services under any other claiming process established by County.

This document defines the procedures which must be followed by Physician in seeking reimbursement under this Program. Submission of a claim by Physician under these procedures establishes (1) a contractual relationship between the County and Physician covering the services provided and (2) signifies Physician's acceptance of all terms and conditions herein.

These claiming procedures are effective July 1, 2005; are only valid for covered services to the extent that monies are available therefore; and are subject to revisions as required by State laws and regulations and County requirements. This claiming process may not be used by a physician if he or she is an employee of a County hospital.

II. PHYSICIAN ELIGIBILITY

A. Physician must complete a current fiscal year Physician Services for Indigents Program "Conditions of Participation Agreement" and "Program Enrollment Provider Form" and provide them to the County's Emergency Medical Services ("EMS") Agency in care of the contracted Claims Adjudicator (see address on page 5). Physician claims will not be accepted if said Agreement is not on file with the EMS Agency.

B. Physicians who provide emergency services to eligible patients in a Los Angeles County (1) basic or comprehensive emergency department of a licensed general acute care hospital, (2) standby emergency department that was in existence on January 1, 1989 in a small and rural hospital as defined in HSC, section 124840, or (3) site approved by the County prior to January 1, 1990, as a paramedic receiving station for the treatment of patients with emergency medical conditions, may submit claims hereunder, if all the following conditions are met:

1. Emergency services are provided in person, on site, and in an eligible service setting.

2. Emergency services are provided on the calendar day on which emergency services are first provided, and on the immediately following two calendar days.

Physician employees of a County hospital are not, however, eligible for reimbursement under this claiming process.

C. Physicians who provide medically necessary obstetric or pediatric services to an eligible patient in a hospital, emergency department, or private office located in Los Angeles County, other than a hospital, emergency department or office owned or operated by the County, may submit a claim hereunder. However, no physician may submit a claim for services provided in a primary care clinic which receives funding under provisions of Chapter 1331, Statutes of 1989.

D. An emergency physician and surgeon or an emergency physician group with a gross billings arrangement with a hospital located in Los Angeles County shall be entitled to receive reimbursement for services provided in that hospital, if all of the following conditions are met:

1. The services are provided in a basic or comprehensive general acute care hospital emergency department.

2. The physician and surgeon is not an employee of a County hospital.

3. All provisions of Section III of these Billing Procedures are satisfied, except that payment to the emergency physician and surgeon, or an emergency physician group, by a hospital pursuant to a gross billings arrangement shall not be interpreted to mean that payment for a patient is made by a responsible third party.

4. Reimbursement is sought by the hospital or the hospital's designee, as the billing and collection agent for the emergency physician and surgeon or an emergency physician group.

For the purposes of this section, a "gross billings arrangement" is an arrangement whereby a hospital serves as the billing and collection agent for the emergency physician and surgeon, or an emergency physician group, and pays a percentage of the emergency physician and surgeon's or group's billings for all patients.

III. PATIENT ELIGIBILITY/BILLING EFFORTS

Only patients who do not have health insurance coverage for emergency services and care, cannot afford to pay for services rendered, and for whom payment will not be made through any private coverage or by any program funded in whole or in part by the federal government, including Medi-Cal, are covered by this claiming process.

During the time prior to submission of the bill to the County, Physician must have made reasonable efforts to obtain reimbursement and not received payment for any portion of the amount billed. For purposes of this claiming process, reimbursement for unpaid physician billings shall be limited to the following:

(a) patients for whom Physician has conducted reasonable inquiry to determine if there is a responsible private or public third-party source of payment; and

(b) patients for whom Physician has billed all possible payment sources, but has not received reimbursement for any portion of the amount billed; and

(c) either of the following has occurred:

1. A period of not less than three (3) months has passed from the date Physician billed the patient or responsible third party, during which time Physician has made reasonable efforts to obtain reimbursement and has not received payment for any portion of the amount billed.

2. Physician has received actual notification from the patient or responsible third party that no payment will be made for the services rendered.

Upon receipt of payment from the County under this claiming process, Physician must cease any current, and waive any future, collection efforts to obtain reimbursement from the patient or responsible third party. During the period after a claim has been submitted and prior to receipt of payment, the Physician can continue attempts to collect from a patient. However, once the Physician receives payment from the County, further collection efforts shall cease.

Examples of when these County collection efforts might occur would include, but not necessarily be limited to, situations where there are third-party tortfeasors responsible for a patient's medical expenses. If, after receiving payment from the County hereunder, Physician is reimbursed by a patient or a responsible third party, Physician

shall immediately notify the County (see address below) in writing of the payment, and reimburse the County the amount received from the County.

MAKE REFUND CHECK PAYABLE TO:
County of Los Angeles
Department of Health Services

Refund checks should be accompanied by:
-- a copy of the Remittance Advice, and
-- a specific explanation for the refund, e.g., received payment for services from Medi-Cal, etc.

SUBMIT NOTIFICATION AND/OR REFUND TO:
County of Los Angeles
Department of Health Services
Fiscal Services
313 North Figueroa Street, Room 505
Los Angeles, CA 90012
ATTN: Chip Program

IV. CONDITIONS OF REIMBURSEMENT

Payment is contingent upon adherence to State law and County requirements regarding eligible claims, and provision of data as specified in these Billing Procedures.

V. CLAIM PERIOD

Claims may only be submitted for eligible services provided on/or after July 1, 2005 and through June 30, 2006. All claims for services provided during the fiscal year 2005/2006 (July 1 through June 30) must be received by County's Claim Adjudicator no later than October 31, 2006. Claims received after this fiscal year deadline has passed will not be paid. Unless sooner terminated, canceled, or amended, this claim process shall expire on October 31, 2006.

VI. REIMBURSEMENT

Reimbursement of a valid claim hereunder will be limited to a maximum of 34% of the Official County Fee Schedule (OCFS), not to exceed 100% of Physician charges. The OCFS, which establishes rates of reimbursement deemed appropriate by the County, utilizes the most current Physicians' Current Procedural Terminology (CPT-4) codes in conjunction with the Resource Based Relative Value Scale (RBRVS) unit values and a County determined weighted average conversion factor. The conversion factor for all medical procedures other than anesthesiology is $79.49 per relative unit value. The conversion factor for anesthesiology procedures is $48.77 per relative unit value.

Based on available funding, the initial payment rate for FY 2005/06 has been established at 29% of the OCFS. In order to ensure that all claims are paid at the same rate, this percentage figure may be increased to not more that 34%, based on the anticipated program revenue and the actual volume of claims.

VII. COMPLETION OF FORMS

A. Complete "Fiscal Year 2005/06 Conditions of Participation Agreement" for the current fiscal year Physician Services for Indigents Program (sample attached as Exhibit "D"). Submit one original signed Agreement to the contracted Claims Adjudicator:

American Insurance Administrators (AIA)
Box 34759
Los Angeles, CA 90034-0759

B. Complete one HFCA-1500 Form per patient.

C. Complete one California Healthcare for Indigents Program ("CHIP") Form per patient (sample attached as Exhibit "D"). Physicians are required to provide patient data for services provided in a hospital to the extent the information is available from the hospital. Additional requirements for data submission have been established. Refer to the Instructions for Submission of Claims and Data Collection (attached as Exhibit "C").

VIII. ELECTRONIC BILLING

As an option, the County's Claims Adjudicator can receive claims electronically. The record layout necessary for electronic submission shall be obtained directly from the County Claims Adjudicator at (310) 390-7900.

IX. SUBMIT CLAIM(S) TO COUNTY'S CONTRACTED CLAIMS ADJUDICATOR

American Insurance Administrators
Box 34759
Los Angeles, CA 90034-0759
ATTN: PSIP

X. CLAIM REJECTION AND APPEALS

A. Revised claims previously rejected for incomplete information must be received by the contracted Claims Adjudicator within 20 calendar days from the date of the rejection letter.

B. The Physician must submit an appeal of any denied claim within thirty (30) calendar days from the date of the denied Remittance Advice. A denied claim can be appealed once; however, after the appeal is dispositioned, a further appeal will not be considered. All appeals shall be prepared and sent in accordance with the directions set forth in Exhibit "A".

XI. INFORMATION CONTACTS

For Status of Claims, call:
AIA Physician Hotline - 1 (800) 303-5242

For Program/Policy Issues, call:
Emergency Medical Services Agency
EMS Reimbursement Coordinator
(323) 890-7521

XII. COUNTY LIABILITY/PAYMENT/SUBROGATION

Payment of any claim under this claiming process is expressly contingent upon the availability of monies allocated therefor by the State and by the County of Los Angeles Board of Supervisors. To the extent such monies are available for expenditure under the Physician Services for Indigents Program, and until such available monies are exhausted, valid claims may be paid. Valid claims will be paid in the order of receipt; that is, if a complete and correct claim is received by County, it will have priority over claims subsequently received.

Physician agrees to assign and subrogate all rights that s/he may have against any patient, his/her responsible relative, any third party tortfeasor or any other party for reimbursement as a result of care and services provided by Physician, and/or his/her staff, for which a claim has been submitted to County under the PSIP. At its sole discretion, County, and/or its contractor, may proceed independently against such parties for reimbursement to the extent permitted by law. The rights hereby assigned and subrogated to County under this provision include reimbursement for the full amount of any customary or actually billed charges of Physician, and his/her staff, for patient care and services regardless of the amount the Physician has received under the PSIP. Physician agrees to cooperate with County and/or its contractors in the exercise of the rights assigned and subrogated to County under this provision.

XIII. GENERAL OBLIGATION OF PHYSICIANS SUBMITTING CLAIMS

In addition to any Physician duties specified previously herein, Physicians using this claiming process are obligated as follows:

A. Records/Audit Adjustment

1. Physician shall immediately prepare, and thereafter maintain, complete and accurate records sufficient to fully and accurately reflect the services provided, the costs thereof, all collection attempts from the patient and third-party payers, and revenue collected, if any, for which claim has been made under this claiming process.

2. All such records shall be retained by Physician at a location in Los Angeles County for a minimum of three (3) years following the last date the Physician services to the patient.

3. Such records shall be made available during normal County working hours to representatives of the County and/or State, upon request, at all reasonable times during such three year period for the purposes of inspection, audit, and copying. Photocopying capability must be made available to County representatives during an on-site audit.

4. County may periodically conduct an audit of the Physician's records. Audits shall be performed in accordance with generally accepted auditing standards. The audit may be conducted on a single claim, a group of claims, or a statistically random sample of claims from the adjudicated universe for a fiscal year. The scope of the audit shall include an examination of patient medical and financial records, patient/insurance billing records, and collections agency reports associated with the sampled claims.

Audited claims that do not comply with program requirements shall result in a refund to the County. If the audit was conducted on a statistically random sample of claims, the dollar amount disallowed shall become a percentage of the total paid on the sample, referred to as the exception rate. The audit exception rate found in the sampled claims reflects, from a statistical standpoint, the overall exception rate potentially possible within the universe of adjudicated claims for that fiscal year. This exception rate shall be applied to the total universe of paid claims which will determine the final reimbursement due to the County.

If an audit of Physician or hospital records conducted by County and/or State representatives relating to the services for which claim was made and paid hereunder finds that (1) the records are incomplete or do not support the medical necessity for all or a portion of the services provided, or (2) no records exist to evidence the provision of all or a portion of the claimed services, or (3) Physician failed either to report or remit payments received from patients or third parties as required herein, or (4) the patient was ineligible for services hereunder, or (5) Physician did not otherwise qualify for reimbursement thereunder, Physician shall, upon receipt of County billing therefor, remit forthwith to the County the difference between the claim amount paid by the County and the amount of the adjusted billing as determined by the audit.

County also reserves the right to exclude Physician from reimbursement of future claims for any failure to satisfy conditions of this claiming process.

B. Indemnification/Insurance

By utilizing this claiming process, the Physician certifies that the services rendered by him/her, and for which claim is made, are covered under a program of professional liability insurance with a combined single-limit of not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) aggregate.

By utilizing this claiming process, the Physician further certifies that his/her workers' compensation coverage is in an amount and form to meet all applicable requirements of the California Labor Code, and that it specifically covers all persons providing services on behalf of the Physician and all risks to such persons.

C. Non-discrimination

In utilizing this claiming process, the Physician signifies that he/she has not discriminated in the provision of services for which claim is made because of race,

color, religion, national origin, ancestry, sex, age, physical or mental disability, or medical condition and has complied in this respect with all applicable non-discrimination requirements of Federal and State law.

XIV. COMPLIANCE WITH HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

The parties acknowledge the existence of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ('HIPAA'). Contractor understands and agrees that, as a provider of medical treatment services, it is a 'covered entity' under HIPAA and, as such, has obligations with respect to the confidentiality, privacy, and security of patients' medical information, and must take certain steps to preserve the confidentiality of this information, both internally and externally, including the training of its staff and the establishment of proper procedures for the release of such information, and the use of appropriate consents and authorizations specified under HIPAA.

The parties acknowledge their separate and independent obligations with respect to HIPAA, and that such obligations relate to transactions and code sets, privacy, and security. Contractor understands and agrees that it is separately and independently responsible for compliance with HIPAA in all these areas and that County has not undertaken any responsibility for compliance on Contractor's behalf. Contractor has not relied, and will not in any way rely, on County for legal advice or other representations with respect to Contractor's obligations under HIPAA, but will independently seek its own counsel and take the necessary measures to comply with the law and its implementing regulations.

CONTRACTOR AND COUNTY UNDERSTAND AND AGREE THAT EACH IS INDEPENDENTLY RESPONSIBLE FOR HIPAA COMPLIANCE AND AGREE TO TAKE ALL NECESSARY AND REASONABLE ACTIONS TO COMPLY WITH THE REQUIREMENTS OF THE HIPAA LAW AND IMPLEMENTING REGULATIONS RELATED TO TRANSACTIONS AND CODE SET, PRIVACY, AND SECURITY. EACH PARTY FURTHER AGREES TO INDEMNIFY AND HOLD HARMLESS THE OTHER PARTY (INCLUDING THEIR OFFICERS, EMPLOYEES, AND AGENTS), FOR ITS FAILURE TO COMPLY WITH HIPAA.

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

PHYSICIAN REIMBURSEMENT PROGRAMS

PHYSICIAN REIMBURSEMENT POLICIES

• • • Revised for Fiscal Year 2005/06 • • •

I. POLICY STATEMENT

THE PURPOSE OF THIS POLICY IS TO ENSURE THE COUNTY'S CONFORMANCE WITH STATUTORY AND REGULATORY REQUIREMENTS, AND TO ADDRESS PRIORITIES OF THE HEALTH CARE SYSTEM WHICH ARE CRITICAL TO PROVIDING FOR THE MEDICAL NEEDS OF THE INDIGENT POPULATION, WITHIN THE LEVEL OF AVAILABLE FUNDS.

II. GENERAL RULES

A. Official County Fee Schedule: The Official County Fee Schedule is used to determine reimbursement rates for eligible physician claims. The Official County Fee Schedule, which establishes rates of reimbursement deemed appropriate by the County utilizes the most current Physicians' Current Procedural Terminology ("CPT-4") codes which coincides with the current Resource Based Relative Values Scale ("RBRVS") unit values and a County-determined weighted average conversion factor. The conversion factor for all medical procedures except anesthesiology is $79.49 per relative unit value. The conversion factor for anesthesiology procedures is $48.77 per relative unit value. Reimbursement is also limited to the policy parameters contained herein.

B. Eligible Period: Reimbursement shall be for emergency medical services provided on the calendar day on which emergency services are first provided and on the immediately following two calendar days. EXCEPTION: Trauma physicians providing trauma services at County contract trauma hospitals may bill for trauma physician services provided beyond this period.

C. Nonemergent Pediatric and OB Services: Reimbursement may be provided for nonemergency, medically necessary services **ONLY IF** they are provided to a patient who is under 21 years of age (a pediatric patient) or to a pregnant woman from time of conception until ninety (90) calendar days following the end of the month in which the pregnancy ends (an obstetric patient).

D. Medi-Cal/Medicare Exclusions:

1. Procedures which are not covered in the Medi-Cal Program's Schedule of Maximum Allowances ("SMA") are excluded from reimbursement.

2. Procedures which are covered in Medi-Cal's SMA but require a Treatment Authorization Request ("TAR") are excluded from reimbursement; however, will considered upon appeal and/or provision of applicable operative and/or pathology reports.

3. Claims determined to be Medi-Cal eligible will be denied.

E. Screening Exams: Payment will be made for emergency department medical screening examinations required by law to determine whether an emergency condition exists.

F. Assistant Surgeons: Reimbursement for assistant surgeons will be at a rate of 16% of the primary surgeon's fee.

G. Pediatric Hospitalization Over Five Days: All claims for pediatric patients hospitalized in excess of five calendar days must be accompanied by a statement from the hospital indicating sources the hospital utilized for reimbursement.

H. Patients 65 years of Age or Older: Unless proof of Medicare denial is provided, e.g., copy of denial of Medicare or Medicare card with Part A only, claims for patients 65 years of age or older will be rejected.

I. Multiple Surgery Procedure Codes: Adjudication of claims involving multiple surgery procedure codes performed in an inpatient operating room requires submission of operative reports. No more than five (5) Procedure Codes shall be paid as follows: 100% for 1st Procedure and 50% for the 2nd through 5th Procedures.

J. Nurse Practitioner and Physician's Assistant Services: Physicians and surgeons shall be eligible to receive payment for patient care services provided by, or in conjunction with, a properly credentialed nurse practitioner or physician's assistant for care rendered under the direct supervision of a physician and surgeon who is present in the facility where the patient is being treated and who is available for immediate consultation. Payment shall be limited to those claims that are substantiated by a medical record and that have been reviewed and countersigned by the supervising physician and surgeon in accordance with regulations established for the supervision of nurse practitioners and physician's assistants in California.

III. INELIGIBLE CLAIMS

A. Office Visits: Procedures performed in a physician's office will be denied unless documentation is provided to show that an eligible service was provided to either a pediatric or an obstetric patient. If a claim is made for services provided to an obstetric patient, the expected date of delivery ("EDD") must be included on the CHIP Form (Item #20). An obstetric claim submitted without the EDD will be rejected.

B. Duplicate Procedures: Claims which include duplicate procedures provided to the same patient for the same episode of care are generally excluded from reimbursement. This does not apply for Evaluation & Management codes billed by separate physicians.

C. Unlisted Procedures: Procedures which are not listed in the Official County Fee Schedule are excluded from reimbursement.

D. Non-physician Procedures: Procedures commonly not performed by a physician will be denied (e.g., venipuncture). Claims will be reviewed and considered on appeal only.

E. Insurance Rejections: Claims for patients with potential insurance or other third-party payer coverage will be denied unless a notice of rejection from the insurance company or other third-party payer is provided to the County. The rejection notice should indicate either (1) the patient is not a covered beneficiary or (2) the term of coverage expired prior to the date of the claimed service. If insurance or other third-party coverage has been denied for other reasons, e.g., the deductible has not been met, the type or scope of service has been classified as a nonemergency, or other similar issues denying insurance coverage, the claim will be denied. Where limited insurance policies have been exhausted by hospital billings, physician claims will be reviewed and considered on appeal.

IV. EXCLUSIONS

A. Radiology/Nuclear Medicine (Codes 70002 - 79499): Reimbursement for radiology codes will be limited to "Wet" or "Stat" readings performed while the patient is in the emergency department or other eligible site. Additionally, payment will only be made for the first radiology claim received by the County per patient per episode of care. Subsequent radiology claims for the same patient/episode will be denied.

B. EKG (Code 93010): Reimbursement for EKG codes will only be made for the first EKG claim received by the County per patient per episode of care. Subsequent EKG claims for the same patient/episode will be denied.

C. Pathology (Codes 80104 - 89999): Reimbursement for pathology codes will be limited to codes 86077, 86078, and 86079. Additionally, codes 88329, 88331, and 88332 will be reimbursed only if the pathologist is on site and pathology services are requested by the surgeon.

D. Surgery (Codes 10000 - 69979): There are no exclusions as long as the procedure is covered in Medi-Cal's SMA and does not require a TAR (see Medi-Cal Exclusions in section A. above).

E. Anesthesia: There are no exclusions as long as the procedure is covered in Medi-Cal's SMA and does not require a TAR (see Medi-Cal Exclusions in section A. above).

F. Modifiers: Reimbursement is excluded for all modifiers except radiology.

G. Prior Dx Codes: Reimbursement will no longer be made for wound checks and suture removal.

H. Critical Care (Codes 99291 and 99292): Reimbursement will not be made on critical care codes after the first 24 hours of service.

I. Newborn Care (Inpatient Code 99431 and Emergency Department Code 99283): Reimbursement will only be made once for the same recipient by any provider and only if accompanied by a Medi-Cal denial. V30 through V30.2 codes are reimbursable only if a copy of Medi-Cal denial is provided.

V. ADDITIONAL EXCLUSIONS

Upon approval of the Board of Supervisors, the County may revise the Physician Reimbursement Polices from time to time as necessary or appropriate.

VI. APPEALS

Appeals for claims rejected or denied may be submitted to the Physician Reimbursement Advisory Committee ("PRAC"), a committee of physicians selected by Hospital Council of Southern California and by the Los Angeles County Medical Association. Appeals shall include the CHIP Form, HCFA-1500, operative reports, if applicable, and supporting documents as needed. Appeals shall be mailed to the contracted Claims Adjudicator:

American Insurance Administrators (AIA)
Box 34759
Los Angeles, CA 90034-0759
ATTN: APPEALS UNIT

Exhibit II

COUNTY OF LOS ANGELES
PHYSICIAN SERVICES FOR INDIGENTS PROGRAM

EFFECTIVE JULY 1, 2005

OFFICIAL COUNTY FEE SCHEDULE:

Official County Fee Schedule (OCFS) for Physicians: Utilizes the most current Physicians' Current Procedural Terminology (CPT-4) codes in conjunction with the Resource Bases Relative Value Scale (RBRVS) unit values and a County determined weighted average conversion factor. The conversion factor for all medical procedures other than anesthesiology is $79.49. The conversion factor for anesthesiology is $48.77.

REIMBURSEMENT RATES:

Reimbursement of a valid claim for:

Trauma The initial payment rate in effect on the date of service shall be 50% * of the OCFS, not to exceed 100% of physician charges.

Other Emergency Services The initial payment rate in effect on the date of service shall be 29% of the OCFS, not to exceed 100% of physician charges. In order to ensure that all claims are paid at an equivalent rate, this initial percentage figure may be increased to not more than 34%* of the OCFS and not to exceed 100% of physician charges, based on actual program revenue and the actual volume of claims paid.

* Reimbursement Rates in effect from FY 2001-02 through FY 2004-05